

CONSENT FOR ACQUIRING OR RELEASING OF EYECARE INFORMATION

DATE _____

TO _____ PHONE () _____ FAX () _____

FROM _____ PHONE () _____ FAX () _____

This consent form will serve to give expressed, written consent for _____
to contact _____ for the purposes of releasing my information or
acquiring my information for the purposes of continued eye care health service including a copy of
my prescription and or specifications for eyeglasses and contact lenses.

_____ Ophthalmic prescription _____ Contact lens information

Prescriber's Name:

Date of Eye Exam:

Rx: _____

OD _____

OS _____

PATIENTS NAME _____

PATIENTS BIRTHDATE: _____

ADDRESS _____

PHONE NUMBER () _____ - _____

PATIENT'S SIGNATURE _____

NOTE: This transmission, including any attachments, is intended only for the named recipient(s) above and may contain information that is privileged, confidential and/or exempt from disclosure under applicable law. If you have received this transmission in error, or are not the named recipient(s), please immediately notify the sender by phone or fax and destroy this transmission, including any attachments. Thank you.

Form Endorsed by

